Adult Case History Form

General Information Date: _____________

Name:______________________________ Date of Birth:____________ Age: ____________

Home Address:____Phone:_____________

Street City/State Zip Code

Cell Phone: ________________________ E-mail: ____________________________

Campus Address:____Phone:____________

Street City/State Zip Code

Referred by:______________________ Reports to be sent to:___________________________

Name and relationship of person filling out form: ______________________________________

Address:____Phone:____________

Street City/State Zip Code

Employment History (most recent)

	Place	Date	Position
1.			
2.			
3.			
4.			

Physicians

	Name	Address	Phone
1.			
2.			
3.			

Marital Status __________________ Spouse:__________________ Age:___________

Children: Name: __________________ Age: ___ Name: ________________ Age:_______

__________________ Age: ___ Name: ________________ Age:_______

__________________ Age: ___ Name: ________________ Age:_______

__________________ Age: ___ Name: ________________ Age:_______

Other persons living in home and relation to family:

____

____

Educational History

	School	Location	Highest grade completed or degree	Date
1.				
2.				
3.				

DESCRIBE YOUR PRESENT HEALTH: ____

Do you have a history of medication or treatment of:

	YES	NO		YES	NO
Allergies			Glandular Imbalance		
Sinus Infection			Hyperthyroidism		
Anemia			Hypothyroidism		
Asthma			Heart trouble		
Broken Nose			Numbness		
Bronchitis			Paralysis/paresis		
Chronic laryngitis			Mouth-breathing		
Cleft palate			Mumps		
Diabetes			Pneumonia		
Chronic ear infections			Poliomyelitis		
Hearing problem			Scarlet fever		
Rheumatic fever			Tremors		
Emotional difficulty			Visual problems		
Tobacco use:			High fever		
-How much per day?			Swallowing difficulties		
Alcohol use:			Other: ______________________________		
-How much per day?					

If the answer to any of the above items is "yes", give the relevant details (e.g., how frequent are these episodes, how severe are these episodes, and treatment you are receiving):

____

____

____

List periods of hospitalization of medical treatment:

Hospital/ City/ State	**Date/ Reason**
1. ________________________________	______________________________ ______________________________
2. ________________________________	______________________________ ______________________________
3.________________________________	______________________________ ______________________________

List all surgical procedures:

____

____

List all prescription and nonprescription medication used over the past year (name the type if you can not remember the generic name, i.e. aspirin, allergy pills, etc.).

____
____
____

Have you had a neurological examination? _______________ If so, by whom, when, and where?

____
____
____

If you speak a language other than English, please state the language___________________ Are you bilingual? Yes____________ No____________

Please describe in your own words the nature of your communication problems.

____
____

What do you think caused the problem? ____

When did you first notice its presence? ____

What were the circumstances?

____
____

Have any members of your family had hearing or speech problems?

____
____

How do you feel your speech problem has affected your social life?

____
____

How do you feel your speech problem has affected your occupation?

____
____

If you didn’t have a speech problem, how would your life be different?

____
____

Describe the reaction of people, including you immediate family, to your speech problems.

____
____

Do any specific communication situations present difficulty for you? ______________________
Explain:
____
____

Do you avoid any communication situations? ____________ Explain: ______________________

List interests you have or activities you engage in (clubs, hobbies, organizations, etc.):
____
____

What, if anything, have you tried to do to correct the speech problem?
____
____

Are you coming to the Speech and Hearing Clinic on your own?
____

On the advice of another? ____

Have you ever received any prior speech and hearing evaluation? _________________________

Therapy? ____
Agency: _______________________________ Agency: _______________________________
Address: ______________________________ Address: ______________________________
Dates: ________________________________ Dates: ________________________________
Results: _______________________________ Results: ______________________________

Did prior evaluation or therapy relate to the present problem?
____
____

How effective has prior therapy been in helping you with your problem (what helped the most/least)?
____
____

If therapy was terminated, describe why: ____
____
How long has the present problem existed? ____
Has the nature of the problem changed at any time? ___________________________________
Explain: ____
____
List any additional sources of information, which may be helpful to us in assisting with your problem:
____
____